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9 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
**DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2010-285

12 **WENDY BELGER**  
13 11356-H Via Rancho San Diego  
14 El Cajon, CA 92019

**ACCUSATION**

15 **Registered Nursing License No. 525288**

16 Respondent.

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18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
21 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department  
22 of Consumer Affairs.

23 2. On or about August 14, 1996, the Board of Registered Nursing issued Registered  
24 Nursing License Number 525288 to Wendy Belger (Respondent). The Registered Nursing  
25 License was in full force and effect at all times relevant to the charges brought herein and will  
26 expire on August 31, 2010, unless renewed.

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8. Title 16, California Code of Regulations, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. Title 16, California Code of Regulations, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

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"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

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"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

## COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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**FIRST CAUSE FOR DISCIPLINE**

**(Unprofessional Conduct-Sleeping While on Duty)**

11. Respondent is subject to disciplinary action under Code section 2761(a) for unprofessional conduct in that Respondent abandoned her station and slept while on duty. The circumstances are as follows.

12. Respondent began working at Richard J. Donovan Correctional Facility (hereinafter "Donovan") as a staff RN through a temporary agency in 2004. In 2005, she was hired by the State of California to work at Donovan as a registered nurse. As an RN at Donovan, Respondent's duties included caring for ill inmates, renewing inmates' medications through doctor's orders and conducting general health assessments of the inmates, including performing suicide checks on mental health crisis patients when necessary. Respondent's typical work shift was between 1400 hours to 2200 hours.

13. On September 11, 2006, Respondent was assigned to the Mental Health Crisis Beds. As the Mental Health Crisis Beds Registered Nurse, Respondent was required to perform suicide checks on all mental health crisis patients every fifteen minutes.

14. Patient 1 and Patient 2 were mental health crisis patients at Donovan. Physician's orders for these patients included suicide checks and observation every 15 minutes. On September 11, 2006, Respondent documented in Patient 1's medical chart that Respondent checked on Patient 1 at 1800 hours and that Patient 1 was reading. Respondent documented she checked on Patient 1 every 15 minutes through 2200 hours. At 2200 hours, Respondent documented that Patient 1 was sleeping. On September 11, 2006, Respondent documented in Patient 2's medical chart that she checked on Patient 2 every 15 minutes from 1500 hours through 2200 hours. Respondent documented that at 1800 hours Patient 2 was "quiet" and documented that at 2000 hours, Patient 2 was still "quiet".

15. At about 1800 hours on September 11, 2006, registered nurse SR observed Respondent lying down on an examination table in the Correctional Treatment Center examination room with the lights out. Two hours later, at about 2000 hours, Supervising Registered Nurse LK, was performing rounds of the Correction Treatment Center and observed

Respondent lying on the examination table with the lights out. Respondent appeared to be sleeping. When LK called out Respondent's name, Respondent jumped up from the table.

16. On March 18, 2006, while Respondent was on duty at Donovan, registered nurse D.B. observed Respondent going into an examination room with a blanket. D.B. later observed Respondent curled up on the examination table sleeping. D.B. noted that Respondent slept from 100 hours to 300 hours and after getting up to give medication, slept until approximately 400 hours. As such, Respondent missed checking on Patient I. every 15 minutes for suicide checks during her entire shift.

### **SECOND CAUSE FOR DISCIPLINE**

#### **(Incompetence-Sleeping While on Duty)**

17. Respondent is subject to disciplinary action under Code section 2761(a)(1) in conjunction with title 16, California Code of Regulations ("CCR"), sections 1443 and 1443.5(1) for incompetence in that Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse when she abandoned her station, slept while on duty, and was therefore unable to observe and formulate a nursing diagnosis of the mental health crisis patients to which she was assigned, as is more fully set forth in paragraphs 12-16 above and incorporated by this reference as though set forth in full herein.

### **THIRD CAUSE FOR DISCIPLINE**

#### **(Gross Negligence-Sleeping While on Duty)**

18. Respondent is subject to disciplinary action under Code section 2761(a)(1) in conjunction with title 16, CCR, section 1442, for gross negligence in that Respondent's conduct of sleeping while on duty is an extreme departure from the standard of care, which under similar circumstances, would have ordinarily been exercised by a competent registered nurse in that Respondent repeatedly failed to perform suicide checks on Patient 1, Patient 2 and Patient I every 15 minutes as ordered by their physicians. Since Patients 1, 2 and I were placed on suicide checks, Respondent knew or should have known that her failure to perform the suicide checks

1 could have jeopardized the patients' health or life, as more fully set forth in paragraphs 12-15  
2 above and incorporated by this reference as though set forth in full herein.

3 **FOURTH CAUSE FOR DISCIPLINE**

4 **(Incompetence-Falsification of Records)**

5 19. Respondent is subject to disciplinary action under Code section 2761(a)(1) in  
6 conjunction with title 16, CCR, sections 1443 and 1443.5 for incompetence in that Respondent  
7 failed to exercise that degree of learning, skill, care and experience ordinarily possessed and  
8 exercised by a competent registered nurse when she falsified patient records to indicate she  
9 performed suicide checks of Patients 1 and 2 every 15 minutes as required by physician's orders  
10 although she was actually sleeping while on duty during those intervals, as is more fully set forth  
11 in paragraphs 12-15 above, and incorporated by this reference as though set forth in full herein.

12 **FIFTH CAUSE FOR DISCIPLINE**

13 **(Gross Negligence-Falsification of Records)**

14 20. Respondent is subject to disciplinary action under Code section 2761(a)(1) in  
15 conjunction with title 16, CCR, section 1442, for gross negligence in that Respondent's conduct  
16 of falsifying patient records to indicate she performed suicide checks of Patients 1 and 2 every 15  
17 minutes as required by physician's orders although she was actually sleeping while on duty  
18 during those intervals is an extreme departure from the standard of care, which under similar  
19 circumstances, would have ordinarily been exercised by a competent registered nurse, as is more  
20 fully set forth in paragraphs 12-15 above, and incorporated by this reference as though set forth in  
21 full herein.

22 **SIXTH CAUSE FOR DISCIPLINE**

23 **(Unprofessional Conduct-Use of Profane Language)**

24 21. Respondent is subject to disciplinary action under Code section 2761(a)(1) for  
25 unprofessional conduct in that a number of Donovan staff members witnessed Respondent using  
26 profane language and discussing graphic sexual details of her personal life while on duty. Staff  
27 members observed Respondent make obscene gestures toward inmate patients, use profanity  
28 when speaking with the inmate patients and badger inmate patients to a state of rage.

1           22. On April 8, 2006, at approximately 2015 hours, inmate C, who had multiple self-  
2 inflicted lacerations, was brought to the Triage and Treatment area for admission into the Mental  
3 Health Crisis Bed unit because he claimed to be suicidal. At this time inmate C was calm and  
4 cooperative. Respondent, who was assigned to a different area, arrived in the Triage and  
5 Treatment area and began speaking to inmate C as follows: "Listen, you f\_\_\_\_ a \_\_\_\_\_. There is  
6 nothing f\_\_\_\_ wrong with you. You are just being a dumb s\_-\_-\_- and you need to go back  
7 to the yard" or similar words. Registered nurse M.B., who was in the process of admitting C  
8 asked Respondent to leave but Respondent continued to badger C with more profanity until C  
9 grabbed a mayonnaise stand tray and threw it at Respondent. At this point, the inmate had to be  
10 handcuffed and placed in a security cell. Respondent continued to use profanity when speaking  
11 with registered nurse M.B.

#### 12                                   **SEVENTH CAUSE FOR DISCIPLINE**

##### 13                                   **(Incompetence-Leaving IV Line Open to Air)**

14           23. Respondent is subject to disciplinary action under Code section 2761(a)(1), in  
15 conjunction with sections 2761 and title 16, CCR, section 1443.5(3) for incompetence in that on  
16 April 11, 2006, Respondent disconnected an IV from a patient but left the IV tubing dangling and  
17 uncapped allowing it to be contaminated. The IV had to be replaced. Respondent failed to  
18 exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a  
19 competent registered nurse when she failed to use sterile techniques when inserting or changing  
20 IV lines.

#### 21                                   **PRAYER**


22           WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
23 and that following the hearing, the Board of Registered Nursing issue a decision:

- 24           1. Revoking or suspending Registered Nursing License Number 525288, issued to  
25 Wendy Belger;
- 26           2. Ordering Wendy Belger to pay the Board of Registered Nursing the reasonable costs  
27 of the investigation and enforcement of this case, pursuant to Business and Professions Code  
28 section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 12/7/09

  
LOUISE R. BAILEY, M.ED., RN  
Interim Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
*Complainant*

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